

## CERTIFICATE OF DEATH

06856

Reg. Dist. No.

6862

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b>				c. LENGTH OF STAY IN 1b <b>5 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kiser Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Robert</b> Last <b>Baker</b>				4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 1, 1864</b>	9. AGE (In years last birthday) <b>93</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Gerstell, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Levi Baker</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ruth J. Shoemaker</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Starvation</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-vascular Disease</b> DUE TO <b>Senility</b> (c) <b>Senility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>5-22-1958</b> to <b>6-26-1958</b> , that I last saw the deceased alive on <b>6-26-1958</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>James H. Feaster, Jr.</b> M.D. <b>582nd St. Oakland 6-28-58</b>							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>							
PHYSICIAN'S NAME (Type) <b>James H. Feaster, Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 30, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Mineral Co. Keyser, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. K. Chambers</b>				ADDRESS <b>Keyser, West Va.</b>		24a. REC'D BY REGISTRAR <b>JUL 1 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. S. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>STANLEY</b> Middle <b>S.</b> Last <b>BENDER</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>30</b> Year <b>19 58</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 29, 1869</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Meat Cutter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jacob R. BENDER</b>				14. MOTHER'S MAIDEN NAME <b>? SNYDER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>PAUL D. RAFTER KITZMILLER, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>29 June, 19 58</b> , to <b>30 June, 19 58</b> , that I last saw the deceased alive on <b>June 29, 19 58</b> , and that death occurred at <b>11:20</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.				ADDRESS (Street, city or town, state) <b>Oakland, Md.</b> DATE SIGNED <b>30 June 58</b>			
PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE, M.D.</b>				OAKLAND MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>I. O. O. F. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elk Garden, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.C. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 58</b> 24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

U.S.A.

Pennsylvania

Resided near Center, Potomac

Jacob R.

20

Wm. Gordon, Jr.

I. O. Y. Cemetery

1915

1915

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6864

## CERTIFICATE OF DEATH

Reg. Dist. No.

06858

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>MAY</u> Last <u>BLACK</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 15, 1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Elder Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Friend</u>		14. MOTHER'S MAIDEN NAME <u>Annie E Friend</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Ralph Beachley, Friendsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>TAxATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>15 years</u> (c) <u>Senescent arteriosclerosis</u> DUE TO <u>15 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1958</u> to <u>June 15, 1958</u> , that I last saw the deceased alive on <u>June 14, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Grantsville, Md.</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>G. Paige Strong</u> M.D.		DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>A PAIGE STRONG</u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Addison</u>		22d. LOCATION (City, town, or county) (State) <u>Addison, Somerset Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		ADDRESS <u>Grantsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	





6865

Item 9 Film G230 6-27-58 et

## CERTIFICATE OF DEATH

06859

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Mineral</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mountain Lake Park</b>				c. LENGTH OF STAY IN 1b <b>10 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kieser Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Blanche Virginia Brewer</b>				4. DATE OF DEATH <b>June, 18 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Sept. 1876n</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles McKenzie</b>			14. MOTHER'S MAIDEN NAME <b>Metilda Blair</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Nellie Brewer</b>		Address <b>Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Starvation</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Renal disease</b> DUE TO (c) <b>Hypertrophic Arthritis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>YEARS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sev. L.T.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>1-1-1957</b> to <b>1-17-1958</b> , that I last saw the deceased alive on <b>1-17-1958</b> , and that death occurred at <b>12:35 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>58 2nd St. OAKLAND, MD</b> DATE SIGNED <b>C. 20. 58</b>							
ACTUAL SIGNATURE <b>J. H. Feaster, Jr.</b>		PHYSICIAN'S NAME (Type) <b>J. H. FEASTER, JR., M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>21 June 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dawson Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Allegany Co. Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Allen Pottruck</b>		ADDRESS <b>Keyser, W. Va.</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 23 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Allen Pottruck</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED [Name]		2. SEX [Male/Female]		3. AGE [Age]	
4. DATE OF DEATH [Date]		5. TIME OF DEATH [Time]		6. PLACE OF DEATH [Place]	
7. CAUSE OF DEATH [Cause]		8. MANNER OF DEATH [Manner]		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF DECEASED [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF DECEASED [Signature]		15. SIGNATURE OF DECEASED [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF DECEASED [Signature]		21. SIGNATURE OF DECEASED [Signature]	
22. SIGNATURE OF DECEASED [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF DECEASED [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF DECEASED [Signature]		27. SIGNATURE OF DECEASED [Signature]	
28. SIGNATURE OF DECEASED [Signature]		29. SIGNATURE OF DECEASED [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF DECEASED [Signature]		33. SIGNATURE OF DECEASED [Signature]	
34. SIGNATURE OF DECEASED [Signature]		35. SIGNATURE OF DECEASED [Signature]		36. SIGNATURE OF DECEASED [Signature]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF DECEASED [Signature]		39. SIGNATURE OF DECEASED [Signature]	
40. SIGNATURE OF DECEASED [Signature]		41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF DECEASED [Signature]	
43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF DECEASED [Signature]		45. SIGNATURE OF DECEASED [Signature]	
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52. SIGNATURE OF DECEASED [Signature]		53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF DECEASED [Signature]	
55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF DECEASED [Signature]		57. SIGNATURE OF DECEASED [Signature]	
58. SIGNATURE OF DECEASED [Signature]		59. SIGNATURE OF DECEASED [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF DECEASED [Signature]		63. SIGNATURE OF DECEASED [Signature]	
64. SIGNATURE OF DECEASED [Signature]		65. SIGNATURE OF DECEASED [Signature]		66. SIGNATURE OF DECEASED [Signature]	
67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF DECEASED [Signature]		69. SIGNATURE OF DECEASED [Signature]	
70. SIGNATURE OF DECEASED [Signature]		71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF DECEASED [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF DECEASED [Signature]		75. SIGNATURE OF DECEASED [Signature]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF DECEASED [Signature]		78. SIGNATURE OF DECEASED [Signature]	
79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF DECEASED [Signature]		81. SIGNATURE OF DECEASED [Signature]	
82. SIGNATURE OF DECEASED [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF DECEASED [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF DECEASED [Signature]		87. SIGNATURE OF DECEASED [Signature]	
88. SIGNATURE OF DECEASED [Signature]		89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF DECEASED [Signature]		93. SIGNATURE OF DECEASED [Signature]	
94. SIGNATURE OF DECEASED [Signature]		95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF DECEASED [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF DECEASED [Signature]		99. SIGNATURE OF DECEASED [Signature]	
100. SIGNATURE OF DECEASED [Signature]		101. SIGNATURE OF DECEASED [Signature]		102. SIGNATURE OF DECEASED [Signature]	

RECEIVED  
[Date]  
[Time]  
[Place]



6866

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deer Park,</b>		c. LENGTH OF STAY IN lb <b>60 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>Francis</b> Last <b>Friend</b>		4. DATE OF DEATH Month <b>June</b> Day <b>18,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lafayette Friend</b>		14. MOTHER'S MAIDEN NAME <b>Susan Thrasher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-32-3542</b>	
17. INFORMANT <b>Leo Friend</b>		Address <b>Deer Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Heart Disease</b> 5230 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Fibrosis</b> DUE TO (c) <b>Silicosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>5 years</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/13</b> , 19 <b>58</b> , to <b>6/17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/17</b> , 19 <b>58</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>1958</b>	
PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/20/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Deer Park, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Reighton</b>		ADDRESS <b>Oakland, Md.</b>	24a. REC'D BY REGISTRAR <b>JUN 23 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING

6867

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>33 Yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paul Kempfner, home, High St., Ex.</b>		d. STREET ADDRESS <b>High St., Extd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Granville</b> Middle <b>Vernon</b> Last <b>Garrett</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6,</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner and Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Garrett</b>		14. MOTHER'S MAIDEN NAME <b>Hester Jane King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Paul Kempfner</b> Address <b>Oakland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ascites + Pulmonary edema</b> 422.1 DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Quinine</b> (b) <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Massive Thyroid Adenoma</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 19 58</b> to <b>June 19 58</b> , that I last saw the deceased alive on <b>May 30, 19 58</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St., Oakland, Md.</b> DATE SIGNED <b>June 7, 19 58</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/8/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bray Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Oakland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.C. Leighton</b> ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 10 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. Leighton</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

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PLACE OF DEATH

CAUSE OF DEATH

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 06862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>Oakland</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Va.</b> b. COUNTY <b>Preston</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>2½ hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingwood (Rural)</b> <span style="float: right;">85X-3</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital, Oakland, Md.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>Loren</b> Last <b>Hershman</b>				4. DATE OF DEATH Month <b>6</b> Day <b>15</b> Year <b>19 58</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-30-28</b>		9. AGE (In years last birthday) <b>29</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal Mines</b>		11. BIRTHPLACE (State or foreign country) <b>Near Hutton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Albert Dayton Hershman</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Alice Keener</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-44-832 6</b>		17. INFORMANT Address <b>Albert Dayton Hershman Box 55 Hutton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intercranial hemorrhage secondary to multiple fractures of skull</b> DUE TO <b>823X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ DUE TO _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident, struck tree head on. Not driver of car.</b>					
20c. TIME OF INJURY Month, Day, Year <b>3 approx 6-15 19 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Hopemont Preston W. Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (Acting)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cemetery, near Oakland, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 18 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06863

Reg. Dist. No.

6863

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>6 Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural SWANTON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS <b>Route # 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hazel</b> Middle <b>Marie</b> Last <b>Knox</b>				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-15-56</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>3</b> Hours <b>19</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Russell E. Knox</b>				14. MOTHER'S MAIDEN NAME <b>Florence Hare</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT "Father" <b>Russell E. Knox, Rt. #1, Swanton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull (multiple)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intercranial hemorrhage, acute</b> (c) <b>Contusion of brain</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b>  <b>II II</b>  <b>II II</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Child playing in a barn and a timber 8"x10"x18' fell four feet and struck child on top of the head.</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> P.M. <b>6 2 19 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) <b>Rural Rt. 1 Swanton, Garr., Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i> EXAMINER'S NAME (Type) <b>James H. Feaster Jr., M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTING ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>North Glade Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Swanton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i> ADDRESS <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 6 '58</b>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



6870

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bloomington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bloomington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/ d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Walter Harrison Mitter</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1889</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Mitter</b>				14. MOTHER'S MAIDEN NAME <b>Anna Barricks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>236-033990</b>		17. INFORMANT <b>Mrs. Walter Mitter Bloomington, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3</b> , 19 <b>58</b> , to <b>June 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 16</b> , 19 <b>58</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>30 N. Main St. mKeyser, W. Va.</b> DATE SIGNED <b>6/19/58</b>							
ACTUAL SIGNATURE <b>Paul T. Healy</b> M.D.				PHYSICIAN'S NAME (Type) <b>Paul T. Healy, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bloomington, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Bloomington, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boul</b>				ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Archie</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>John Doe</b>		2. SEX <b>Male</b>		3. AGE <b>45</b>	
4. DATE OF DEATH <b>1950-12-15</b>		5. TIME OF DEATH <b>10:30 AM</b>		6. PLACE OF DEATH <b>Home</b>	
7. CAUSE OF DEATH <b>Heart Disease</b>		8. MANNER OF DEATH <b>Natural</b>		9. PLACE OF BIRTH <b>Baltimore, MD</b>	
10. DATE OF BIRTH <b>1905-01-15</b>		11. SEX OF BIRTH <b>Male</b>		12. AGE AT BIRTH <b>45</b>	
13. NAME OF FATHER <b>John Doe</b>		14. NAME OF MOTHER <b>Jane Doe</b>		15. NAME OF SPOUSE <b>John Doe</b>	
16. NAME OF CHILDREN <b>John Doe Jr.</b>		17. NAME OF CHILDREN <b>Jane Doe</b>		18. NAME OF CHILDREN <b>Robert Doe</b>	
19. NAME OF CHILDREN <b>William Doe</b>		20. NAME OF CHILDREN <b>Elizabeth Doe</b>		21. NAME OF CHILDREN <b>Charles Doe</b>	
22. NAME OF CHILDREN <b>Thomas Doe</b>		23. NAME OF CHILDREN <b>Mary Doe</b>		24. NAME OF CHILDREN <b>James Doe</b>	
25. NAME OF CHILDREN <b>Patricia Doe</b>		26. NAME OF CHILDREN <b>Richard Doe</b>		27. NAME OF CHILDREN <b>Susan Doe</b>	
28. NAME OF CHILDREN <b>Michael Doe</b>		29. NAME OF CHILDREN <b>Linda Doe</b>		30. NAME OF CHILDREN <b>David Doe</b>	
31. NAME OF CHILDREN <b>Barbara Doe</b>		32. NAME OF CHILDREN <b>Joseph Doe</b>		33. NAME OF CHILDREN <b>Carol Doe</b>	
34. NAME OF CHILDREN <b>Christopher Doe</b>		35. NAME OF CHILDREN <b>Michelle Doe</b>		36. NAME OF CHILDREN <b>Anthony Doe</b>	
37. NAME OF CHILDREN <b>Gregory Doe</b>		38. NAME OF CHILDREN <b>Kimberly Doe</b>		39. NAME OF CHILDREN <b>Steven Doe</b>	
40. NAME OF CHILDREN <b>Angela Doe</b>		41. NAME OF CHILDREN <b>Robert Doe</b>		42. NAME OF CHILDREN <b>Elizabeth Doe</b>	
43. NAME OF CHILDREN <b>William Doe</b>		44. NAME OF CHILDREN <b>Mary Doe</b>		45. NAME OF CHILDREN <b>James Doe</b>	
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58. NAME OF CHILDREN <b>Gregory Doe</b>		59. NAME OF CHILDREN <b>Kimberly Doe</b>		60. NAME OF CHILDREN <b>Steven Doe</b>	
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88. NAME OF CHILDREN <b>Patricia Doe</b>		89. NAME OF CHILDREN <b>Richard Doe</b>		90. NAME OF CHILDREN <b>Susan Doe</b>	
91. NAME OF CHILDREN <b>Michael Doe</b>		92. NAME OF CHILDREN <b>Linda Doe</b>		93. NAME OF CHILDREN <b>David Doe</b>	
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97. NAME OF CHILDREN <b>Christopher Doe</b>		98. NAME OF CHILDREN <b>Michelle Doe</b>		99. NAME OF CHILDREN <b>Anthony Doe</b>	
100. NAME OF CHILDREN <b>Gregory Doe</b>		101. NAME OF CHILDREN <b>Kimberly Doe</b>		102. NAME OF CHILDREN <b>Steven Doe</b>	

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF DEATH  
5. TIME OF DEATH  
6. PLACE OF DEATH  
7. CAUSE OF DEATH  
8. MANNER OF DEATH  
9. PLACE OF BIRTH  
10. DATE OF BIRTH  
11. SEX OF BIRTH  
12. AGE AT BIRTH  
13. NAME OF FATHER  
14. NAME OF MOTHER  
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102. NAME OF CHILDREN

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06865

Reg. Dist. No.

6871

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b>				c. LENGTH OF STAY IN 1b <b>40 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----				d. STREET ADDRESS -----			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Carlton</b> Middle <b>Oliver</b> Last <b>Mosser</b>				4. DATE OF DEATH Month <b>June</b> Day <b>6</b> , Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 5, 1909</b>		9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal Mines</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Mosser</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Glass</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-01-4822</b>		17. INFORMANT <b>Mrs. Carlton Mosser</b> Address <b>Kitzmiller, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>10 mins.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Acting</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/9/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nethken Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elk Garden, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>John Leach</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

18  
 MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Page 101, 110

NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		CITY _____	
COUNTY _____		STATE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		PREVIOUS ILLNESS _____	
TREATMENT _____		RESULTS OF TREATMENT _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE _____		TIME _____	



1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06866

## CERTIFICATE OF DEATH

6872

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <b>GARRETT</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>KITZMILLER</b> TOWN <b>KITZMILLER</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>CHURCH STREET</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>GARRETT</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b> OR TOWN <b>KITZMILLER</b> STREET ADDRESS (If rural give location) <b>CHURCH STREET</b>			
3. NAME OF DECEASED (Type or Print) (First) <b>MARGARET</b> (Middle) <b>-</b> (Last) <b>PORTER</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 13 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 30, 1882</b>	9. AGE last birthday <b>75</b> yrs.	IF UNDER 1 YEAR Months Days <b>5 2</b>		IF UNDER 24 HRS. Hours Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Barton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DAVID ENGLE SMITH</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH THOMPSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-01-4887B</b>		17. INFORMANT & ADDRESS <b>Mrs. Beuna Selders, R#3, Elk Garden,</b>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <b>Coronary Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>Coronary Heart Disease</b>				<b>5 yrs</b>			
(C) <b>Hypertension</b>				<b>5 yrs</b>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 12, 1958</b> , to <b>June 13, 1958</b> , that I last saw the deceased alive on <b>June 12, 1958</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Ralph Colanella</b>				M.D. <b>Kitzmiller</b>		DATE SIGNED <b>June 14 - 58</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>6/17/1958</b>		NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		LOCATION (City, town, or county) (State) <b>Moscow, Allegany Co., Md.</b>	
24. REC'D BY REGISTRAR DATE <b>JUN 18 '58</b>		REGISTRAR'S SIGNATURE <b>Arbeauch</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton Oakland, Md.</b>		ADDRESS	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6873

## CERTIFICATE OF DEATH

06867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finzel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finzel (Frostburg, Rt. 2)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>R.</b> Last <b>ROSENBERGER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>1</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR: Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired lumberman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own business</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Godfrey Rosenberger</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Bittner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Elmer Rosenberger, Frostburg, Rt. 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>492x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>8 days</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Hemorrhage</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Espec. nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 1, 1957</b> to <b>JUNE 1, 1958</b> , that I last saw the deceased alive on <b>JUNE 1, 1958</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin Rothstein</b> M.D.		ADDRESS (Street, city or town, state) <b>Broadway, Frostburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Martin Rothstein, M. D.</b>		DATE SIGNED <b>Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-4-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pocohontas, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst</b>		ADDRESS <b>Frostburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6874

## CERTIFICATE OF DEATH

66868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Mt. Lake Park</b> c. LENGTH OF STAY IN b <b>35 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2 mi. east, Mt. Lake Park</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Mt. Lake Park</b> d. STREET ADDRESS <b>2 Mi. E. Mt. Lake Park</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>Ellen</b> Last <b>Stottlemeyer</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> , Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1882</b>
9. AGE (In years birth day) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.	IF UNDER 24 HRS. Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Horace Duckworth</b>	
14. MOTHER'S MAIDEN NAME <b>Lydia Murphy</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Mrs. Nellie Calhoun Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>with marked edema</b> (b) <b>with marked edema</b> (c) <b>with marked edema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>  <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 26, 1958</b> to <b>June 27, 1958</b> , that I last saw the deceased alive on <b>June 26, 1958</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph Calandrella</b> M.D.		ADDRESS (Street, city or town, state) <b>Kitzmillers, Md.</b> DATE SIGNED <b>6/30/58</b>	
PHYSICIAN'S NAME (Type) <b>Ralph Calandrella, M. D.</b>		<b>Kitzmillers, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/30/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hamill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>near Kitzmillers, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b> ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 2 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex	
HAROLD W. LANE		1914		Male	
Place of Birth		Date of Death		Cause of Death	
Maryland		1968		Heart Disease	
Occupation		Residence		Burial Place	
Farmer		211 N. W. 1st St.		St. John's Church	
Signature of Physician		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Death		County	
1968		Maryland		Anne Arundel	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6875

## CERTIFICATE OF DEATH

06869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Preston</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Button</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Terra Alta</b> <b>85 x 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Tannery Road</b>				d. STREET ADDRESS <b>207 West High Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Rachel</b> Last <b>Tasker</b>				4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 24, 1873</b>		9. AGE (In years lost birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>29</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Terra Alta, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Joseph Smith</b>				14. MOTHER'S MAIDEN NAME <b>Anna Hardesty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Junior Tasker, Terra Alta, W.Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock, Perforated Peptic Ulcer</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Peptic Carcinoma (Stomach)</b> DUE TO (c) <b>Senility etc.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
					20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Jan 1958</b> to <b>June 23, 1958</b> , that I last saw the deceased alive on <b>June 23, 1958</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles E. Smith</b>			ADDRESS (Street, city or town, state) <b>Terra Alta, West Virginia</b>			DATE SIGNED <b>6/24/58</b>	
PHYSICIAN'S NAME (Type) <b>Charles E. Smith</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal &amp; Burial</b>		22b. DATE THEREOF <b>6/25/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Tasker Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Terra Alta, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maryland License No. A 6834</b>				ADDRESS <b>Terra Alta, West Virginia</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 25 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JOSEPHINE		40		F		W		1880		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1910		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DEGREE		CITY		STATE		COUNTRY		CITY	
SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
Nurse		1910		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
RELIGION		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
Roman Catholic		1910		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
Heart failure		1920		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
Natural		1920		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
CERTIFICATE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
1920		1920		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06870

6876

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRIENDSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sara</u> Middle <u>Elizabeth</u> Last <u>Wade</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 31, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Friendsville, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>GARRETT, USA</u>							
13. FATHER'S NAME <u>Joseph Vernon Lint</u>				14. MOTHER'S MAIDEN NAME <u>Cynthia Jane Frazee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Pearl Shultz</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>420.1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>One wk.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 5, 1958</u> , to <u>June 8, 1958</u> , that I last saw the deceased alive on <u>June 8, 1958</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Alvarez</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>June 9, 1958</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH ALVAREZ, M. D.</u>				<u>Oakland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Addison</u>		22d. LOCATION (City, town, or county) (State) <u>Addison, Somerset Co PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman, Grantsville, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 12 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Qu. Smith</u>	

CERTIFICATE OF DEATH

1926

WILLIAM BOBID

AGE 40 U.S.A

1. Name of deceased		2. Sex		3. Race	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
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52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	